Ohio State OSCA Chiropractic Association

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Understanding Insurance Verification

We have surveyed many different staff members that have verified insurance. Prior to getting trained almost all of them were verifying insurance the following way:

STAFF: Hello, this is Bharon from Dr. Hoag's office and I am calling to verify chiropractic benefits.

INS: The patient has a 12 visit max per calendar year and a $250 deductible.

STAFF: Thanks have a great day.

I realize this is an exaggeration for most offices but there is not much more information that is gathered on these calls.

Before we can verify patients insurance properly we need to understand exactly what we are looking for. Chiropractors hold a Primary Care Physician (PCP) status. This means there is an umbrella of services that they are allowed to provide under their licensure. Each state creates a scope of practice for chiropractic which tells the physician what they can or cannot do to a patient in that state. This is important because when we get on the phone with the insurance company we need to know if they are giving us proper information or not.

Most chiropractic clinics will provide four main categories of service, **Evaluation and Management (E/M), Physical Therapy (PT), Diagnostics, and Chiropractic**. It is important to understand that all insurance companies have a separate benefit package for these four categories. The question we need to answer is whether the Chiropractor has access to those separate benefits. Although chiropractors have the PCP status that does not mean the insurance company has to honor it as far as benefits go.

It is your job as the insurance verifier to get as much information about the patient's policy as you can. The more information we have the better we will be able to manage the patient.

We have created a new Insurance Verification Form to aid you in this process. I want to take the time to go over each item one by one so you understand why you are asking the question and know what kind of answer you should be getting.

Getting Started:

It is important to control the conversation as much as possible. One of the main complaint's I get from staff is the insurance person just rushed through the information and the staff member felt they could not ask the proper questions. You need to control the conversation right from the beginning.

You need to start the call by breaking their routine, lighten the mood a bit. Below is a suggestion of how to better begin a call :

INS: This is Mary, How can I help you?

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STAFF: Mary, how the heck are ya?

INS: (Laughing) Fine, and how are you?

STAFF: If I was any better, I would be dangerous!

STAFF: Mary, I need to verify outpatient benefits and I am going to do my best to keep you from wanting to shoot me by the end of this phone call. We have a pretty diverse office I am going to need a lot of information from you. I want to make this as easy for you as I can so we can go by category or code, whatever works best for you.

INS: (Laughing) Well, let's go by category because I don't have the codes in my computer.

STAFF: Great, Why don't we start off the all the basic info like effective date, deductibles and co-pays. I will also need both in and out of network coverage. Don't hate me!

INS: I will try not to but you're going to owe me!

That is a pretty realistic example of a typical conversation when I verify insurance. It is important that you control the flow of the call so you get everything you need. Trust me, it is not every day they hear a person on the other end of the line with that kind of personality. Having fun with them will help you to get them on your side. After all aren't we here to bless others? Are these not people just like your patients. They have a tough job and we should want to brighten their day. I know that is not easy to do but feel it is worth the effort!

Let's go through the Verification Form item line by line:

First Box:

Calling to Verify Out Patient Benefits

Most offices will call and verify chiropractic coverage. This is incorrect. You need to understand that you are not a chiropractic office in the eyes of the law. You are an outpatient facility. This changes the entire environment of your ability to submit CPT codes and receive reimbursement. Because the scope of practice for a chiropractor in the state of Ohio allows them to provide other services like E/M code, Therapies, X-rays. That changes their ability to have access to different benefit packages with in the plan. If you simply verify the chiropractic coverage alone you are missing vital information you need to process the patient.

It is important to understand we are not trying to miss represent who we are, rather we need to be as accurate as possible. By stating we are verifying outpatient benefits we let them know we have a lot of questions. They will know it is a chiropractic office from your Tax ID. We just do not want them to get stuck on the chiropractic benefits and not tell us the rest.

You will find more about this below.

Name of the person verifying the insurance

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This is more important when you have more than one person verify insurance in your office. It is there to help determine who verified that particular insurance.

Date, Time, Contact Person, Employee ID

This information is really only important for one reason. There are times when you will be told that there is coverage on a specific category like PT. You bill according to the verification and a month later you get an Explanation of Benefits (EOB) and your therapies are denied because it is a non-covered service. You go back and look at the insurance verification and it shows that it is covered. If you have the date, time, person's name and ID you spoke to you have a chance of getting it paid. Most insurance companies will record the conversation you have with their agents. You can call the insurance and have them review that particular conversation and if they find that you were told it was a covered service then they have to pay those services to date. You will not get it covered for future visits.

You will notice that when you call to verify insurance that there is a disclaimer that every insurance company says at some point in the conversation. The disclaimer basically states that these are not a guarantee of payment. That does not mean that this phone call is pointless. What they are saying is that they are not guaranteeing that you will get the full 70% or that will not get 12 visits if you can't prove medical necessity. If they tell you a service is covered, then it should be cover to some extent.

Second Box:

Patient name thru Claim Address

This information is pretty basic and should be self-explanatory. You will get this information either off the New Patient Phone Interview or the Intake Form.

Effective Date

This is the date that the patient started coverage with the insurance company. It is normally not that important but you are going to want to pay attention to the date. If the date they give you is within the last six months then you are going to want to make sure you pay attention to the Pre-existing section at the bottom of the second box. It is not all that often that it will happen but when it does it is very important you catch it. If the policy has a pre-existing and you do not catch it you are libel to end up eating a lot of money.

Let me give you an example. Let's say a patient comes to your office complaining about low back pain and you do your exam and give the patient a low back diagnosis. You were unaware the patient had a workers compensation claim about six years ago on his low back. The date of the visit was Jan. 5th 2004 and the effective date on the policy is Dec. 1st 2003. When the patient filled out the paper work for his insurance he indicated to them his past low back issues. The insurance company put a pre-existing clause on his policy that says anything with a low back diagnosis will not be cover by them. You don't realize any of this for approximately 30 – 60 days from his first visit when you received the first EOB. The patient has been seen 15 times by this point and his balance is $1,645.00. You will have no hope of collecting on this money at that point.

This is a realistic example; you just need to pay attention to the date. If it is greater than six months I would not worry about it too much.

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Deductible

A deductible is a dollar amount the patient needs to pay before the insurance company will start paying for a portion of the care. Most insurance companies will have an individual and/or family amount. You will need to find out what the deductible is and if any of it has been met and what is left. This is very important in order to find out what the patient is responsible for. You also want to make sure you find out if the deductible renews every calendar year or policy year. More and more carriers are going to a policy year deductible which makes the effective date even more important. You may find times when the insurance companies will tell you that this information is not available because it would be a violation of HIPAA. If you do not already know this, that is not true. HIPAA has no relativity in this situation. It is SO important that you understand the law so you can stand up for your rights.

Met

When you ask for the deductible amount you need to find out if the patient has met any of this amount to date. You need to write that amount in this location.

Out of Pocket / Out of Pocket Met

In every policy there is an out of pocket amount. Most policies will have a $1000 - $2000 out of pocket. This number represents the actual amount the patient pays out of their own pocket. You need to make sure you ask if the deductible is inclusive of this amount or exclusive. If it is inclusive, meaning that the deductible amount goes toward the out of pocket, you need to pay attention to this account around the 15 – 25 visits. It is very possible that on paper you will reach this amount.

It is important that you understand how the insurance company looks at these numbers. All the insurance company has to go off of are the CMS's you submit. If the policy has a $500 deductible and $200 has been met, it covers at 70/30 and has a 40 visit max. Once the CMS values add up to $300, remaining deductible, the insurance will then begin paying 70 percent of the allowed procedures. If your visit cost is $100 they will pay $70 and they are assuming the patient has paid $30 for that visit. Once the patient portion has accumulated to the out of pocket amount the insurance will cover at 100 percent. This, I would think, is a handy bit of information.

Make sure you ask how much has been met to this point.

You need to document this information in the patients account in your computer system. Most software's will have a pop-up box that will remind you of these limits and keep you aware.

Reimbursement % after Ded met / Co-Pay

This is pretty strait forward. You will put the 80/20, 70/30, whatever that particular policy has. Most insurance will have either a co-insurance or co-pay. The co-insurance is the 70/30 or partnership coverage with the insurance company. Co-pay is a set dollar amount that does not changed based on the dollar amount of the individual visit. In most cases this percentage amount will be the same for all benefits with in this policy. You will not need to ask for the payment percentage on each category.

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Pre-Existing

As addressed above, a pre-existing clause can be very important but rarely is it relative. Most policies will not have a pre-existing clause. When you ask if there is any pre-existing you should receive a yes or no answer. If the answer is yes, then you will need to make sure you and the patient call the insurance company on their first visit to find out what that clause is. You can have the patient request the insurance company fax it to your office. You will be unable to get this information from the insurance company due to HIPAA.

Specific Coverage Questions:

As I have stated above, the way you communicate and the words you choose to use are so vital in the way the call goes as well as the quality of the information you will receive. All of the categories of care we have spoken about are covered in most insurance plans. So to ask if a service is covered is not the right question. You need to be asking what the limitation of that particular category is.

For example, you will not ask if Physical Therapy is covered. Instead you will ask what the limitations for physical therapy are. This will allow the insurance a person to give you the information you are truly looking for.

The verification form is laid out in a specific manner. You will be asking for Chiropractic benefits last. We are not trying to hide the fact that it is a chiropractic office but at the same time we need to remember that first and foremost your office is a doctor's office. Therefore you need to make sure the agent on the other end of the phone does not assume anything about you or your office. By verifying chiropractic last you are able to get the true benefits in the other categories. Let's review each category now.

Physical Therapy:

You will see on the form that this category is laid out a bit different. Because physical therapy is such a broad benefit there is often more limitation. You will first ask what the limitations are. You should be told a visit maximum. Something like 40 – 60 visits. You then need to ask if there is any specific restriction. Limit per day, specific non-covered services and max dollar amount per day.

Physical therapy bills in units meaning the more time you spend the more you can bill. Some payers will restrict the amount you can bill per day.

Take your time with this category and make sure you get all the information.

Evaluation and Management (E/M):

In this category you are looking for the limitations on your evaluation codes (99203, 99213). In most cases they will tell you that it is based on medical necessity, which means it is an unlimited benefit as long as the service is necessary. In some cases I have seen them only cover the initial E/M.

There are times they will say that the E/M's are not subject to the deductible. This means that it will be covered at any point even if the deductible is not met.

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Diagnostics:

Depending on what services you offer this will be a short section. Typically x-rays will be the only thing that falls into this category. If you offer additional diagnostic services such as computerized Range of Motion and Muscle testing, Dynamic EMG or any other test, you will need to verify that specifically. I would have the proper code on your form for these extra procedures and ask for the benefit by the code billed. If you do any type of Orthotic work, i.e. foot levelers, I would add it to this category as well.

Make sure there are no additional deductible or restrictions on the specific procedure.

Chiropractic:

In this category a couple of things could happen. They could simply give you the limitations which are typically a visit max or dollar amount max or, they could begin asking you a bunch of question.

Unfortunately in the world of healthcare chiropractors are viewed as specialists. Surprisingly though this is not the case. According to all 50 states scope of practice as well as Medicare, a chiropractor is considered a physician!

When you get to this category they may begin asking you if it is a chiropractor that will be providing all of the service. BE HONEST! Tell them yes. They will most likely say that in that case all services fall under the chiropractic benefit. Don't get all bent out of shape yet. We need to educate those around use to the laws in your state. If this situation happens to you then just simply tell them that in the state of _____, your doctor is considered a physician and a primary care physician, therefore he/she is entitled to the same reimbursement as an MD.

At this point you need to move on to the last three questions of the form.

Even if the above situation never happened you need to make sure this payer is going to give you access to each of the benefits verified. To do this you need to ask the question:

Does it matter which provider provides the service as long as they are licensed to provide it in the state?

Essentially you are telling them that the chiropractor is providing all of the service but that they are licensed to do so, and want to see if the payer will cover them. They may not understand your question so simply put it into laymen's terms for them.

You are looking for an answer of "NO, it does not matter as long as they are licensed". This means that we have access to all the individual benefits. If however they say "Yes, it matters, if it is a chiropractor providing the service then everything falls under chiro, or they say it must be a licensed physical therapist in order to have coverage" then you need to move on to the next question.

Does an MD have access?

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Here we are asking if an MD billed for rehab would they have access to the benefit. We are asking this to make sure they are not discriminating against our field. All 50 states have passed a non-discrimination clause to their state law. This law states that if both the MD and DC are within their scope and bill the same procedure they BOTH must be paid. Meaning, if a payer covers the service for the MD then they must cover it for the DC, as long as they are licensed to perform that procedure.

After asking the question they say "No, it must be a licensed physical therapist" then we know they are discriminating against use. At this point explain to them that in your state the DC is licensed to provide the same services as a PT, in the eyes of the state they are an equivalent to a PT and therefore have access to the benefit. You fight this by providing the payer with a copy of your states scope of practice for chiropractors.

If however they say "Yes, we would pay the MD" then they are discriminating again us and we need to move to the next question.

Are you governed by state statues?

As stated above every state has passed a non-discrimination clause or law. We need to find out if this particular payer is self-funded and therefore not governed by these laws. If you look at the verification form you will see at the tops of the "specific coverage criteria" that you already ask them if they are self-funded, I still want you to ask if they are governed by state law.

If they are governed by state law then you simply need to warn them. Should they deny you access to the individual benefits then you will be reporting them to the state insurance commissioner's office for violating the non-discrimination act in your state. You suggest they put a note on your account that says to give you access to those benefits. At this point that is all you can do, they have not denied you yet so you have no rights but you just let them know you are not the normal push over.

If however they are not governed by state law the new really have no recourse and you truly are restricted to the chiropractic coverage.

Insurance verification is one of the most important things in your office. If we do not get all the information then we will most likely make mistakes and either charge the patient too much or not enough, either case is unacceptable. Take the time to do this right and it will save you a tremendous amount of work on the back end.

As always if you have any question about the system give us a call (614) 229-5290

Good Luck and happy hunting!